IN THE UK COVID-19 PUBLIC INQUIRY

BEFORE BARONESS HEATHER HALLETT

IN THE MATTER OF:

THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

Submissions on behalf of Covid-19 Bereaved Families for Justice UK and NI Covid-19 Bereaved Families for Justice for the Module 3 preliminary hearing on 10 April 2024

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1. These submissions are provided on behalf of Covid-19 Bereaved Families for Justice UK (CBFFJ UK) and NI Covid-19 Bereaved Families for Justice (NI CBFFJ) in advance of the Inquiry's Module 3 preliminary hearing on 10 April 2024, at which it has been confirmed that the CBFFJ UK and NI CBFFJ families' representatives intend to make oral submissions.

2. These submissions follow the agenda of the preliminary hearing on 10 April 2024, save with respect to the first: discrimination.

Discrimination

3. Disparities of outcome for some racialised minorities is a persistent factor in most aspects of this Inquiry. It is vital that issues of structural and institutional discrimination should be considered with respect to disproportionate outcomes, and all other aspects of healthcare, and with respect to both patients and staff. Whereas some of the evidence from earlier modules will be relevant to these issues, there is a need for further healthcare-specific evidence in this regard. These issues include, but are by no means limited to, the disproportionate number of BAME healthcare staff who died, whether (and why) persons of particular minorities were disproportionately in the front line, whether policies and equipment took proper account of racial characteristics, and whether some 111 algorithms discriminated against black patients.

4. Similarly, there is a need for investigation and evidence relating to other forms of disproportionate outcome and discrimination, including on the basis of sex, gender, age, and disability, and intersectionality between different aspects of discrimination, unequal outcome and treatment. There are widespread concerns that people with mental health conditions, intellectual disabilities, Downs Syndrome, and people living with dementia, fared far worse than others, and whether different policies were applied to older people and disabled people to their disadvantage. We note that the provisional outline of scope document published on 8 November 2022 has not been updated and makes no mention of discrimination.

5. In the first instance, we submit that the Inquiry should instruct its existing experts to produce addendum reports, and where necessary, instruct further experts to address these Module 3-specific matters. The evidence should include recognition of these issues and planning (a general issue which we address in more detail below), and what occurred to mitigate these known factors in the response.

(a) Rule 9 requests and witnesses

Spotlight hospitals

6. In December 2023 CPs were informed that the Inquiry had selected 22 'Spotlight hospitals'. The criteria used has been described in CTI's Note of 13 March 2024. As we understand the position, the selection has taken account of relative populations within each nation/jurisdiction, and differences between urban and rural facilities. The selection has taken account of questionnaire responses in order to obtain a sufficiency of evidence concerning systemic issues, but it is not designed to be a comparative exercise, or to balance perceived performances during the pandemic. We do not have an objection to this approach in principle, however, there has been no consultation with CPs on the selection of spotlight hospitals which is a missed opportunity for the Inquiry to receive information from those healthcare staff, patients, and relatives who were most closely affected, and to consider comments about the selection or methodology, which may have enhanced the process.

7. In Northern Ireland, the selection is the two main urban hospitals, which omits consideration of healthcare in rural areas. The two hospitals in Wales are both in South Wales, which excludes the experience across the rest of the country.

8. It is also unclear whether the hospitals chosen reflect areas with diverse racial and ethnic communities who were disproportionately affected in the pandemic, and the Inquiry is invited to indicate how it has taken this into account in its selection process.

9. The CTI Note says that Rule 9 requests have been sent to the Chief Medical Officers (or equivalent roles) within each spotlight hospital, and the intention is to obtain non-corporate responses. Although it is laudable to ensure the 'Spotlight' evidence is not simply a corporate view, CBFFJ UK and NI notes that CMOs are board members of Trusts / Health Boards, and have an obvious motivation to present a rose-tinted perspective. In our view, it is essential that the Inquiry seeks evidence from a variety of sources. These should include patient groups, Patient Advice and Liaison Service, professional bodies and trade unions. We are concerned that the current approach will not achieve the legitimate aim sought, unless this is done.

10. CBFFJ UK and NI has three further concerns. Firstly, the healthcare pandemic issues plainly go much further than hospitals. A similar approach should be taken to other services, including: ambulance trusts, GP surgeries and other frontline community healthcare centres, mental health facilities, and the 999 and 111 provision.

11. Secondly, although we welcome a wide investigation of the evidence, it is unclear as to how the Inquiry will be able to call and properly interrogate this evidence within the timetable set. Prior to the decision to proceed in this way, we had proposed a panel of experts to assist in considering evidence from hospitals and other facilities and services. We would welcome further discussion and consultation on this issue, if possible before the preliminary hearing.

12. It is worth considering in more detail the issues that arises from the selection of the spotlight hospitals in Northern Ireland, Altnagelvin Area Hospital in Derry and Royal Victoria Hospital in Belfast. CBFFJ NI harbour real concerns that the exclusive focus on these hospitals will inevitably be at the exclusion of other hospitals. In particular, the hospitals chosen are the largest hospitals in Northern Ireland situated in the two largest urban conurbations in Northern Ireland. In Northern Ireland, about 670,000 people live in rural areas, which is approximately 37% of the population.[1] In England, the mid-year population estimate for 2020 was 56.6 million, of which 9.7 million (17.1%) lived in rural areas and 46.9 million (82.9%) lived in

[1] BBC website, 'People in Northern Ireland's rural areas 'are happier'' available at: https://www.bbc.co.uk/news/uk-northern-ireland-41397806

urban areas.[2] It is for these reasons that we provided a Rule 9 request for the CEOs of each of the Trusts in Northern Ireland so that the widest possible experience can be considered by the Inquiry, including capturing the unique challenges faced by hospitals that serve border communities with the most cross-border patients. In the first instance, we ask that the Inquiry consider including one smaller, rural hospital in Northern Ireland as a spotlight hospital, for example Daisyhill hospital, Newry. In the alternative, we ask that the Inquiry make those Rule 9 requests to the Trust CEOs and keep open the possibility of including other hospitals as spotlight hospitals in the light of those Rule 9 replies.

13. We are also concerned that the focus on a very limited number of hospitals will be at the expense of consideration of wider, systemic issues that were faced by the population and which have been highlighted by our client groups. For example, focusing on a few hospitals is unlikely to show the inconsistency of approach as between hospitals to, for example, DNACPR policies and their implementation, and the prescription of end-of-life drugs (in particular midazolam).

Preparedness

14. Thirdly, it was said by CTI in Module 1 that preparedness in the NHS would be dealt with in Module 3.

15. The issues of preparedness – resilience, capacity and planning - like other issues including discrimination and health inequalities, run throughout each of the modules. These are not issues which were 'done' in Module 1, and they are particularly apposite to Module 3.

16. At the first Module 1 preliminary hearing on 4 October 2022, Hugo Keith KC asserted that Module 1 "*cannot be used as a vehicle to front-load others issues better suited for scrutiny later in the Inquiry*" (Page 28/29, Lines 23-3).

17. At the second Module 1 preliminary hearing on 14 February 2023, Mr Keith stated that, "high-level preparedness on the part of the United Kingdom Government and devolved administrations will of course be addressed in Module 1 but sectorial and operational readiness will be addressed as part of your later modules" (Page 16, Lines 5-12).

[2] Official Statistics: Rural population and migration updated 28 October 2021available at: https://www.gov.uk/government/statistics/rural-population-and-migration/rural-population-and-migration

18. At the third Module 1 preliminary hearing on 25 April 2023, Mr Keith further clarified:

> *"The third area concerns whether or not preparedness in hospitals and care homes falls within Module 1. This is an issue which is raised by one particular core participant. My Lady, in our submission, and of course again it's a matter for you, the answer is: no. Whilst Module 1 of course will look at high level planning, the manner in which in general terms the UK Government and the devolved administrations declared how hospitals and care homes should prepare for civil emergencies and pandemics, the more detailed examination of preparedness in hospitals and care homes, especially at an operational level, must be for the healthcare and care sector modules.."* (Page 18, Lines 7-25)

19. It has been understood therefore that NHS preparedness (both capacity and resilience, and planning) would be dealt with in Module 3. CBFFJ UK is concerned that §13 of CTI's note of 13 March 2024 explains that the Rule 9 requests to the 22 spotlight hospitals do not deal with preparedness, only what happened when the pandemic struck. The note references "staff shortages just prior to and during the pandemic", but each spotlight hospital should be asked what plans they had as a Trust / Health Board for an epidemic/pandemic, and what their understanding of national planning relevant to their hospitals were, in particular including IPC, testing, and visitation. They should also be asked what their resilience was: this includes staff shortages, but also bed capacity, surge capacities, triage systems, stockpiling, medical equipment, oxygen supplies and PPE. Without dealing with those issues, the Inquiry will hear only half the story.

20. We have previously addressed the utility in sharing Rule 9 requests with CPs. This issue illustrates the problem where they are not shared.

Family evidence

21. This topic has been considered under the heading 'Impact evidence' (CTI Note §15+). However, the Inquiry has recognised the importance of taking evidence of *systemic* issues in Module 3 from family members and others affected. Our families have an array of experiences across many of the Inquiry's Module 3 themes. We urge upon the Inquiry the importance of calling a proportionate number of bereaved family witnesses from diverse backgrounds and locations across the UK, who can speak to a range of systemic issues relevant to Module 3.

22. Whatever the utility of the parallel Every Story Matters project, the voices of those most affected need to be heard within the Inquiry room and be part of the evidence before it. Their voices and lived experiences are essential to the inquiry. To that end, we intend to provide the Inquiry team with a schedule of family members from whom we consider the Inquiry would benefit from hearing oral evidence. These are bereaved family members some of whom also have experience as healthcare staff both at front line level as health care workers, but also in some instances as management. They have a unique perspective on the pandemic and their evidence will provide considerable value to the Inquiry. It is inevitable that they will number more than five. Moreover, limiting the responses to five individuals from each CP group risks missing the nature and breadth of systemic issues across the 4 jurisdictions.

23. Consequent to recent correspondence we note that the Inquiry is seeking assistance from a wide range of those affected, not only the bereaved. Although the Inquiry will want to hear from a broad spectrum of experience, and has limited time, we urge the selection process to take account of the central position of the bereaved, and with respect to CBFFJ UK, the substantial number of families we represent, across the four nations and jurisdictions. In accordance with the request to us we will indicate, within the schedule we submit, those family members whom we consider will be able to assist most. We urge the Inquiry not to adopt a preconceived, disproportionate selection criteria, as appears to be the case from the correspondence. We make this submission without prejudice to distinct issues of other CPs, in particular healthcare workers (many of whom are within our group), and to other important issues such as Long Covid.

(b) Disclosure to Core Participants

24. We note the late disclosure of large quantities of material in Module 1 and Module 2. It is essential that disclosure of material for Module 3 is made expeditiously to enable proper preparation and exploration of the issues and to assist in effective preparation of questions to witnesses.

25. CBFFJ UK and NI understand the pressures faced by people working in healthcare, and the pressures on the Inquiry. However, public authorities must understand that the Inquiry and CPs are working to a strict timetable. The answer to high demand is to apply more resources, and we note that many Trusts / Health Boards have recruited Inquiry liaison staff. Delay not only

causes stress for families and witnesses, but may end up wasting resources if there are knock-on consequences. Module 3 covers a vast array of issues in all four nations, and it is imperative for the Inquiry to use all its considerable powers to ensure compliance with deadlines. We respectfully welcome the recent issue of Section 21 notices, although we note that these were with regard to requests made nine months earlier. Given the fact that the substantive hearings are now less than 6 months away, we urge the Inquiry to demand earlier compliance from all evidence providers, and swifter disclosure to CPs.

26. Unlike in Module 1 and Module 2, public bodies have had ample time to prepare for Module 3 and we urge disclosure to be considerably increased soon. Not only will there be a lot of preparation for everyone involved in Module 3 but subsequent modules follow quickly thereafter, and the Inquiry and some CPs will need to prepare concurrently. We note that Module 4 is already delayed as a result of evidence-gathering issues. Going forward, late production to the Inquiry and late disclosure from the Inquiry must be avoided at all costs.

27. We note with concern that a number of important Rule 9s were only sent out recently, including to two Health Secretaries. We seek reassurance that no other important witness statement requests remain outstanding

28. Further, we note that the Inquiry has considered it necessary to issue a section 21 notice to the Department of Health Northern Ireland for provision of approved draft witness statements and associated exhibits by specified dates. The serious concerns over disclosure that this decision plainly represents reinforces our client's fears and experiences in Module 2C. We therefore welcome the indication that compliance with these notices will be kept under review and consideration given to escalating compliance measures where necessary.

29. We do understand that in all Inquiries, disclosure continues up to and during hearings. However, we urge the Inquiry to commit to the disclosure of the majority of Module 3 material by the end of June 2024, in order that all CPs have proper opportunity to review the documents and be ready for 9 September 2024.

(c) Expert witnesses

30. CBFFJ UK and NI asks the Inquiry to share the 'letters of instruction' to all experts with CPs. Only if the LOIs are shared can the CPs understand the intended scope of the report and make

submissions on areas that may have not been addressed. This assists the Inquiry and avoids potential delay.

31. We note that the primary care experts are both from Wales and have been instructed to write a report which (presumably) covers all four nations/jurisdictions. That is a considerable task, and we request confirmation that they have the requisite knowledge and experience. Without sight the LOI we do not know whether the experts have been instructed to review preparedness and resilience of primary care services in the event of an epidemic or pandemic. It would be insufficient if this report only deals with the response of primary care to the pandemic, given the above general submissions on preparedness within Module 3.

32. We make the same point in relation to the 'infection prevention and control' experts: we submit that they should be instructed to provide an opinion on preparedness in all four nations, and ask for reassurance of the same.

33. We note that the Inquiry's intention to appoint a panel of experts to comment on infection prevention and control (IPC) has not gone to plan. Before the last Module 3 preliminary hearing, we invited the Inquiry to circulate a longlist of suggestions to CPs for their views, a suggestion that has not been taken up. The Inquiry's approach of facilitating comments by CPs only after draft reports have been prepared may result in missed opportunities and indeed the identification of appropriate experts who can produce reports within the time frame.

34. Similar to our recent submissions in M6, we submit that the Inquiry should instruct an expert to consider the preparedness and response of the healthcare systems of two other countries with a similar economic profile to the UK, and whose healthcare sectors have been perceived to have fared better than the UK. The purpose of this is not to examine where the UK came in an international league table, but to learn lessons for the future. By learning about what went 'right' in other countries, the Inquiry can develop meaningful questions to Module 3 witnesses, and such evidence would inform potential recommendations for the future. In our submission, this would be a proportionate approach which could have real impact on the Inquiry.

35. The Inquiry is aware that health is a devolved issue. We welcome the broad range of experts instructed by the Inquiry on issues of Long Covid, critical care, infection prevention and control and non-Covid conditions. However, given the intricacies of Northern Ireland's system, which uniquely integrates health and social care (including cross-border healthcare services) and has the only land border within the UK, we repeat our submission that it is essential that an expert

in Northern Irish health and social care be appointed. This is to ensure that the Inquiry can comprehend fully the pandemic's effect on the healthcare system in Northern Ireland and to avoid important elements of a combined health and social care system inadvertently falling between the cracks caused by the hearing of isolated Inquiry modules.

(e) Public hearings

36. We note that half-term is not the same in every area, and support calls to push back the two-week break in Module 3 by one week to accommodate those with child-care duties.

37. CBFFJ UK and NI remains concerned that 40 hearing days will be insufficient to deal properly with the considerable array of Covid-related topics, and five non-Covid conditions in all four nations plus 22 spotlight hospitals. We consider that a further preliminary hearing is important to consider the witness list and timetabling.

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